DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 3 2

2. STATE: Iowa

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
August 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.201, 447.302

7. FEDERAL BUDGET IMPACT:
a. FFY 01 $ 0
b. FFY 02 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, pages 1 through 26 and 26a through 26e

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, page 1 (MS-99-34), page 2 (MS-96-38), pages 3 and 3a (MS-97-30), page 4 (MS-96-38), pages 5 and 6 (MS-99-34), page 7 (MS-96-38), pages 8 and 9 (MS-99-34) page 10 MS-97-30), page 11 (MS-99-34), page 12 (MS-96-38), page 13 (MS-97-30), page 14 (MS-99-34), page 15 (MS-96-38), page 16 (MS-99-34), page 17 (MS-99-12), pages 18 and 19 (MS-96-38), page 20 (MS-99-34), pages 21 through 25 (MS-96-38), page 26 (MS-00-21), pages 26a-26e (MS-99-34

10. SUBJECT OF AMENDMENT:
Change in hospital payment methodology for direct and indirect medical education and a disproportionate share of poor patients

11. GOVERNOR'S REVIEW *(Check One)*:

☑ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Jessie K. Rasmussen

14. TITLE:
Director

15. DATE SUBMITTED:
September 6, 2001

16. RETURN TO:
Director
Department of Human Services
Hoover State Office Building
Des Moines, IA 50319-0114

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
09/06/01

18. DATE APPROVED:
MAR 14 2002

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
08/01/01

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Thomas W. Lenz

22. TITLE:
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23. REMARKS:
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SPA CONTROL
Date Submitted: 09/06/01
Date Received: 09/10/01

Methods and Standards for Establishing Payment Rates for Inpatient Hospital Care

1. Introduction

Medicaid reimbursement for inpatient hospital care is based on payment according to diagnosis-related groups (DRG). These rates are rebased and the DRG weights are recalibrated once every three years.

This state plan reflects the fourth rebasing and recalibration, implemented October 1, 1999. The current DRG payment is established through a base-year rate (1998) to which an annual legislative index may be applied on July 1 of each year.

The reimbursement amount is a blend of hospital-specific and statewide average costs reported by each hospital, for the routine and ancillary base and capital cost components, per Medicaid discharge.

Direct medical education, indirect medical education, and disproportionate share payments are made directly from the Graduate Medical Education and Disproportionate Share Fund. They are not added to the reimbursement for claims.

2. Definitions

Certain mathematical or technical terms may have a specific meaning used in this context. The following definitions are provided to ensure understanding among all parties.

"Adolescent" means a Medicaid patient 17 years of age or younger.

"Adult" means a Medicaid patient 18 years of age or older.

"Average daily rate" means the hospital's final payment rate multiplied by the DRG weight and divided by the statewide average length of stay for a DRG.

"Base-year cost report" means the hospital's cost report with a fiscal year ending on or after January 1, 1998, and before January 1, 1999. Cost reports shall be reviewed using Medicare cost reporting and cost reimbursement principles for those cost-reporting periods.

For cost reporting periods beginning on or after July 1, 1993, reportable Medicaid administrative and general expenses are allowable only to the extent that they are defined as allowable using Medicare Reimbursement Principles or Health Insurance Reimbursement Manual 15 (HIM-15).

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Appropriate, reportable costs are those that meet the Medicare (or HIM-15) principles, are reasonable, and are directly related to patient care. Costs are considered to be reasonable when they do not exceed what a prudent and cost-conscious buyer would pay for a given item or service.

Inclusion in the cost report of costs that are not directly related to patient care or are not in accord with Medicare principles of reimbursement is not appropriate. Examples of administrative and general costs that must be related to patient care to be a reportable cost are:

- Advertising
- Promotional items
- Feasibility studies
- Dues, subscriptions or membership costs
- Contributions made to other organizations
- Home office costs
- Public relations items
- Any patient convenience items
- Management fees for administrative services
- Luxury employee benefits (i.e., country club dues)
- Motor vehicles for patient care
- Reorganization costs

"Blended base amount" means the case-mix-adjusted, hospital-specific operating costs per discharge associated with treating Medicaid patients, plus the statewide average, case-mix-adjusted operating cost per Medicaid discharge, divided by two. This base amount is the value to which add-on payments for inflation and capital costs are added to form a final payment rate.

"Blended capital costs" means hospital-specific capital costs, plus statewide average capital costs, divided by two.

"Capital costs" means an add-on to the blended base amount which shall compensate for Medicaid's portion of capital costs. Capital costs for building, fixtures, and movable equipment are defined in the hospital's base-year cost report, are case-mix adjusted, are adjusted to reflect 80% of allowable costs, and are adjusted to be no greater than one standard deviation off the mean Medicaid blended capital rate.

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"Case-mix adjusted" means the division of the hospital-specific base amount or other applicable components of the final payment rate by the hospital-specific case-mix index.

"Case-mix index" means an arithmetical index used to measure the relative average costliness of cases treated in a hospital as compared to the statewide average.

"Children's hospitals" means hospitals with inpatients predominantly under 18 years of age.

"Cost outlier" means a case that has an extraordinarily high cost, so as to be eligible for additional payments above and beyond the initial DRG payment.

"Diagnosis-related group (DRG)" means a group of similar diagnoses based on patient age, organ systems, procedure coding, comorbidity, and complications.

"Direct medical education costs" means costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an inpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital's base-year cost reports, and is inflated and case-mix-adjusted in determining the direct medical education rate.

For claims with discharge dates on or after July 1, 1997, the direct medical education payment is made from the Graduate Medical Education and Disproportionate Share Fund and is not added to the reimbursement for claims.

"Direct medical education rate" means a rate calculated for a hospital reporting medical education costs on the Medicare cost report (HCFA-2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by inflation factors. The result is further divided by the hospital's case-mix index, then is divided by net discharges. This formula is limited by funding availability that is legislatively appropriated.

"Disproportionate-share payment" means a payment that shall compensate for costs associated with the treatment of a disproportionate share of poor patients. For claims with discharge dates on or after July 1, 1997, the disproportionate-share payment is made directly from the Graduate Medical Education and Disproportionate Share Fund and is not added to the reimbursement for claims.

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"Disproportionate share percentage" means either (1) the product of 2 ½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2 ½ percent.

"Disproportionate share rate" means the sum of the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate multiplied by the disproportionate share percentage.

"DRG weight" means a number that reflects relative resource consumption as measured by the relative charges by hospitals for cases associated with each DRG. The Iowa-specific DRG weight reflects the relative charge for treating cases classified in a particular DRG compared to the average charge for treating all Medicaid cases in all Iowa hospitals.

"Final payment rate" means the aggregate sum of the two components (the blended base amount and capital costs) that, when added together, form the final dollar value used to calculate each provider's reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing.

"Full DRG transfer" means that a case coded as a transfer to another hospital shall be considered to be a normal claim for recalibration or rebasing purposes if payment is equal to or greater than the full DRG payment.

"Graduate Medical Education and Disproportionate Share Fund" means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed, or nominally reimbursed patients.

"Indirect medical education costs" means costs that are not directly associated with running a medical education program, but are incurred by the facility because of that program (for example, costs of maintaining a more extensive library to serve those educational needs).

For claims with discharge dates on or after July 1, 1997, the indirect medical education payment is made from the Graduate Medical Education and Disproportionate Share Fund and is not added to the reimbursement for claims.

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"Indirect medical education rate" means a rate calculated as follows:

- The statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two, added to the statewide average capital costs, divided by two.
- The resulting sum is then multiplied by the ratio of the number of full-time equivalent interns and residents serving in a Medicare-approved hospital teaching program divided by the number of beds included in hospital departments served by the interns' and residents' program, and is further multiplied by 1.159.

"Inlier" means a case where the length of stay or cost of treatment falls within the actual calculated length-of-stay criteria, or the cost of treating the patient is within the cost boundaries of a DRG payment.

"Long-stay outlier" means a case that has a length of stay that is greater than the calculated length-of-stay parameters, as defined with the length-of-stay calculations for that DRG.

"Low-income utilization rate" means the ratio of gross billings for all Medicaid, bad debt, and charity care patients, including billings for Medicaid enrollees of managed care organizations and primary care case management organizations, to total billings for all patients. Gross billings do not include cash subsidies received by the hospital for inpatient hospital services except as provided from state or local governments.

"Medicaid-certified unit" means a hospital-based substance abuse, psychiatric, neonatal, or physical rehabilitation unit that is certified for operation by the Iowa Department of Inspections and Appeals on or after October 1, 1987. Medicaid certification of substance abuse, psychiatric, and rehabilitation units is based on the Medicare reimbursement criteria for these units. A Medicare-certified physical rehabilitation unit or hospital in another state is considered Medicaid-certified.

"Medicaid inpatient utilization rate" means the number of total Medicaid days, including days for Medicaid enrollees of managed care organizations and primary care case management organizations, both in-state and out-of-state, and Iowa state indigent patient days divided by the number of total inpatient days for both in-state and out-of-state recipients. Children's hospitals receive twice the percentage of inpatient hospital days attributable to Medicaid patients.

"Neonatal intensive care unit" means a neonatal unit designated level II or level III unit using standards set forth in Section 19, Payment for Medicaid-Certified Special Units.

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"Net allowable hospital-specific base costs" means the hospital-specific base costs or charges, as reported, from which have been subtracted the costs associated with capital and direct medical education, as well as calculated payment amounts associated with indirect medical education, transfers, outliers, and physical rehabilitation services.

"Net discharges" means total discharges minus transfers and short-stay outliers.

"Net number of hospital-specific Medicaid discharges" means the total number of Medicaid discharges reported by a hospital, less the actual number of transfer cases and short-stay outliers.

"Outlier" means a case that has an extremely short or long length of stay (day outliers) or an extraordinarily high cost (cost outlier) when compared to other discharges classified in the same DRG.

"Peer review organization (PRO)" means the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy, and quality of care; appropriateness of admission, discharge, and transfer; and appropriateness of a representative sample of prospective-payment outlier cases.

"Rate-table listing" means a schedule of rate payments for each provider. The rate table listing is defined as the output that shows the final payment rate, by hospital, before being multiplied by the appropriate DRG weight.

"Rebasing" means the redetermination of the blended base amount or the capital cost components of the final payment rate from more recent Medicaid cost report data.

"Recalibration" means the adjustment of all DRG weights to reflect changes in relative resource consumption.

"Short-stay day outlier" means a case that has a length of stay that is less than the calculated length-of-stay parameters, as defined within the length-of-stay calculations.

"Transfer" means the movement of a patient from a bed in a non-Medicaid-certified unit of a hospital to a bed in a Medicaid certified unit of the same hospital or to another hospital.

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3. Definition of Allowable Costs

Allowable costs are those defined as allowable in 42 CFR, Chapter IV, Part 405, Subpart D, excluding 42 CFR 405.430 and including routine cost limits as specified in 42 CFR 405.460, except as specifically excluded or restricted in the state plan.

Costs are allowable only to the extent that they relate to patient care; are reasonable, ordinary and necessary; and are not in excess of what a prudent and cost-conscious buyer would pay for the given service or item. Only those costs are considered in calculating the Medicaid inpatient reimbursable cost per discharge for the purpose of this plan.

4. Explanation of the Cost and Rate Calculations

The base-year allowable costs used for determining the hospital-specific cost per discharge and the statewide average cost per discharge can be determined by using the individual hospital's 1998 Medicare Cost Report (HCFA-2552), Worksheets D-1 and D-4, as submitted to the state.

The total number of Medicaid discharges can be determined from documents labeled PPS-1 and PPS-2, Worksheet S-3 in the report or the MMIS claims documentation system.

a. Calculation of Hospital-Specific and Statewide Net Medicaid Discharges

The total number of Medicaid discharges is determined from the number reported in the cost report or the MMIS claims documentation system. Subtracted from this total number of discharges for each hospital are discharges that have been paid as transfers or short-stay outliers.

This number is known as the net hospital-specific number of discharges. To arrive at the statewide net number of discharges, all net hospital-specific numbers of discharges are summed.

b. Calculation of the Hospital-Specific Case-Mix-Adjusted Cost Per Discharge

As determined from the 1998 base-year cost report, the hospital-specific case-mix adjusted cost per discharge is calculated by starting from:

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The **lower** of total Medicaid costs **or** covered reasonable charges for each Iowa hospital (LOCOC) less 20% of capital expenses
- The remaining 80% of actual costs reported for capital expenditures
- The actual costs reported for direct medical education
- Calculated payments made for non-full DRG transfers
- Calculated payments made for outliers
- Payment made for physical rehabilitation (if included)

= Net allowable base costs or charges

The net allowable base costs or charges amount is then inflated, case-mix-adjusted and divided by the net number of hospital-specific Medicaid discharges to obtain the hospital-specific case-mix-adjusted cost per discharge, as shown:

Net allowable base costs or charges
× Hospital inflation update factor
= Inflated net allowable base cost
÷ Hospital-specific case-mix index
= Inflated, case-mix-adjusted net allowable base costs or charges
÷ Net hospital-specific Medicaid discharges (less non-full DRG transfers and short stay outliers)
= Hospital-specific case-mix-adjusted cost per discharge.

c. Calculation of the Statewide Average Case-Mix-Adjusted Cost per Discharge

The statewide average case-mix-adjusted cost per discharge is calculated from:

The **LOCOC figures** for each Iowa hospital less 20% of actual capital costs as reported
- The remaining 80% of hospital-specific capital costs
- Hospital-specific direct medical education costs
- All hospital-specific payments for transfers
- All hospital-specific payment for outliers
- All hospital-specific payments for physical rehabilitation (if included in above)
- All hospital-specific payments for indirect medical education

= Hospital-specific net base cost for statewide average

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The hospital-specific net base cost for the statewide average is then case-mix adjusted.

Net hospital-specific base cost for statewide average
÷ (Total number of Iowa Medicaid discharges minus the number of non-full DRG transfers and short-stay outliers)
= Case-mix-adjusted hospital-specific base costs for statewide average

Next, to arrive at the statewide average cost per discharge, sum all the case-mix-adjusted hospital-specific base costs for the statewide average from above, and divide by the total number of net Medicaid discharges for all Iowa hospitals.

+ Hospital 1 case-mix-adjusted base costs
+ Hospital 2 case-mix-adjusted base costs
+ Hospital 3 case-mix-adjusted base costs
+ Hospital N case-mix-adjusted base costs
= Sum of case-mix-adjusted statewide allowable base costs
÷ Sum of the statewide net Medicaid discharges (less non-full DRG transfers and short-stay outliers)
= Statewide average case-mix-adjusted cost per discharge

d. Calculation of the Final Blended Base Rate

To calculate the final blended base rate, the hospital-specific case-mix-adjusted cost per discharge is added to the statewide average case-mix-adjusted cost per discharge and divided by 2.

5. Calculation of the Capital Component to the Final Blended Base Rate

Added to the final blended base rate is a component that reflects the individual hospital's cost for capital-related expenditures. The capital cost component is a 50/50 blend of hospital-specific capital costs and statewide average capital costs.

The capital-related costs are found in the last column of HCFA-2552, Worksheet B, Part II and Part III. These costs are then apportioned to Medicaid using Medicaid patient days and ancillary charges. Routine costs are reflected in Worksheet D, Part I. Ancillary costs are reflected in Worksheet D, Part II.

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The capital component is calculated by taking the sum of the routine and ancillary capital-related costs from the submitted Medicaid cost report, multiplying by 80%, dividing by the hospital-specific case-mix index and then dividing by the net number of Medicaid discharges for that hospital.

Hospitals whose blended capital add-on exceeds one standard deviation from the mean Medicaid capital rate will be subject to a reduction in their capital add-on to equal the greatest amount of the first standard deviation.

The sum of the hospital-specific routine and ancillary capital costs multiplied by 0.8
÷ Hospital-specific case-mix index
= Case-mix-adjusted capital cost component
÷ Net number of hospital-specific Medicaid discharges
= Case-mix-adjusted hospital-specific capital cost per discharge

The statewide average capital cost per discharge is determined by adding together all hospital-specific case-mix-adjusted capital costs for all Iowa hospitals. This total is divided by the total statewide number of net Medicaid discharges. The total number of net discharges is calculated by adding together all the hospital-specific net discharge figures for all Iowa Medicaid discharges. Net discharges are defined within Section 4, paragraph (a).

+ Hospital 1 case-mix-adjusted capital costs
+ Hospital 2 case-mix-adjusted capital costs
+ Hospital 3 case-mix-adjusted capital costs
+ Hospital N case-mix-adjusted capital costs
= Statewide total case-mix-adjusted capital costs
÷ Statewide total number of net Medicaid discharge
= Statewide average case-mix-adjusted capital cost per discharge

The blended capital cost component is determined by adding together the hospital-specific case-mix-adjusted capital cost per discharge and the statewide average case-mix-adjusted capital cost per discharge and dividing by 2. This blended capital rate component is added to the final blended base rate.

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6. Calculation of the Direct Medical Education Rate

Direct medical education costs are reflected in the cost report when a facility operates a program that qualifies for medical education reimbursement under Medicare. The routine costs are found in the cost report in Worksheet D, Part III. Ancillary costs are found on Worksheet D, Part IV. These costs are apportioned to Medicaid on the basis of Medicaid days and ancillary charges.

The total hospital-specific routine and ancillary direct medical education costs are added together and multiplied by inflation factors. This result is further divided by the hospital's case-mix index, then is divided by the net number of Medicaid discharges for that hospital. This formula is limited by funding availability that is legislatively appropriated.

Routine medical education costs (Worksheet D, Part III)
\+ Ancillary medical education costs (Worksheet D, Part IV)
= Hospital-specific total direct medical education costs
x Inflation factors
= Hospital-specific total inflated direct medical education cost
÷ Hospital-specific case-mix index
= Case-mix-adjusted hospital-specific direct medical education costs
÷ Net hospital-specific number of Medicaid discharges
= Hospital-specific case-mix-adjusted inflated direct medical education cost per discharge

7. Calculation of the Disproportionate-Share Rate

The disproportionate share rate is determined using the following formula: Sum the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate. Multiply this sum by the disproportionate share percentage.

8. Calculation of the Indirect Medical Education Rate

The indirect medical education rate is determined using the following formula:

- The statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two, added to the statewide average capital costs, divided by two.
- The resulting sum is then multiplied by the ratio of the number of full-time equivalent interns and residents serving in a Medicare-approved hospital teaching program divided by the number of beds included in hospital departments served by the interns' and residents' program, and is further multiplied by 1.159.

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9. Trending Reimbursement Rates Forward

The base-year cost for the current rebasing is the hospital's 1998 fiscal year end. A hospital's assigned rate is the 1998 base-year rate that is case-mix-adjusted for each succeeding year. The only adjustments made to this rate are for fraud, abuse, and material changes brought about by cost report reopenings done by Medicare or Medicaid.

The rates have been trended forward using inflation indices of 2.8% for SFY 1998, 0.0% for SFY 1999, 2.0% for SFY 2000, 3.0% for SFY 2001, and (3.0%) for SFY 2002.

10. Ceilings and Upper Limit Requirements

Medicare and Medicaid principles of reimbursement require hospitals to be paid at the lower of customary charges or reasonable cost. This principle is not altered by the DRG reimbursement methodology.

At the end of the cost reporting period, the aggregate covered charges for the period are determined and compared to the aggregate payments made to the hospital under the DRG payment methodology (before any subtraction of third-party payments). If the aggregate covered charges are less than the aggregate payments made using the DRG rates, the amount by which payments exceed the covered charges is requested and collected from the hospital.

This adjustment is performed each year at the end of the hospital's fiscal year, and does not have any impact upon the DRG rates that have been calculated for the next year. There is no carryover of unreimbursed costs into future periods under this DRG reimbursement methodology.

In accordance with 42 CFR 447.271, as part of the final settlement process, the fiscal agent of the Department determines each hospital's total inpatient customary charges for all patients and total days for all patients during the cost reporting period. This is converted to an aggregate customary charge per day.

The fiscal agent then determines the total payments for Medicaid as if this aggregate customary charge per day had been used. Final payment for the cost reporting period in question is made to each hospital at a per-day amount not to exceed its aggregate customary charge per day. This test is applied on a hospital by hospital basis.

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In accordance with 42 CFR 447.272, as part of the final settlement process, the fiscal agent determines the upper payment limit based on Medicare payments. Using Medicare principles of cost reimbursement, the total inpatient costs of each facility are divided by the total number of days or discharges to arrive at a cost per day or discharge. This is multiplied by the total number of Medicaid days or discharges, to arrive at the amount payable by Medicaid, using Medicare cost reimbursement principles.

In accordance with 42 CFR 447.272(a), the application of upper payment limits applies to rates set to pay for inpatient services furnished by hospitals within one of the following categories: (1) State government-owned or operated facilities, (2) Non-State government-owned or operated facilities, or (3) Privately-owned and operated facilities.

In accordance with 42 CFR 447.272(b), payments to hospitals, aggregated by the categories described in 42 CFR 447.272(a), may not exceed a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles.

In accordance with 42 CFR 447.272(c), exceptions are made for:

- Non-state government-owned or operated hospitals, allowing that payments may not exceed 150% of a reasonable estimate of the amount that would be paid for the services furnished by this group of facilities under Medicare payment principles,
- Payments to Indian Health Service facilities and tribal facilities that are funded through the Indian Self-Determination and Education Assistance Act (PL 93-638), and
- Payments made in accordance with an approved state plan to hospitals found to serve a disproportionate number of low-income patients with special needs.

In accordance with 42 CFR 447.272(d), the state is in compliance effective March 13, 2001, with the upper payment limit described in 42 CFR 447.272(b).

In accordance with 42 CFR 447.272(e), the state is in compliance with the schedule of transition periods permitted.

In accordance with 42 CFR 447.253, the Department finds that using the previously described methodology, the Medicaid payments made under this plan would not exceed the amount the Department would pay under the Medicare/TEFRA principles of reimbursement. This applies to state-owned, non-state government-owned, and privately-owned facilities.

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11. Explanation of Iowa-Specific Relative Weights

Diagnosis-related groups are categories established by HCFA and distributed by 3M. The number of DRGs is determined by HCFA, and is updated when needed. A DRG weight is a relative value associated with the charge for treating a particular diagnosis when compared to the cost of treating an average discharge. The recalculation of the Iowa-specific weights is called recalibrating.

Iowa-specific weights have been calculated using applicable claims for the period of January 1, 1997, through December 31, 1998, and paid through March 31, 1999. The recalibrating includes all normal inlier claims, the estimated inlier portion of long-stay outliers, transfer cases where the payment is greater than or equal to the full DRG payment, and the estimated inlier portion of cost-outlier cases. Short-stay outliers and transfer cases where the final payment is less than the full DRG payment are discarded from that group. This group is known as "trimmed claims."

a. Iowa-specific weights are calculated from Medicaid charge data using trimmed claims with discharge and admission dates occurring from January 1, 1997, through December 31, 1998, and paid through March 31, 1999.

   One weight is determined for each DRG except for Medicaid-certified special units, as defined in Section 19. There are multiple weights for the DRGs affected by those Medicaid-certified special units. The weight used for payment corresponds to the certification level of the specific hospital. Weights are determined as follows:

   1. Determine the statewide geometric mean charge for all cases classified in each DRG.

   2. Compute the statewide aggregate geometric mean charge for each DRG by multiplying the statewide geometric mean charge for each DRG by the total number of cases classified in that DRG.

   3. Sum the statewide aggregate geometric mean charges for all DRGs and divide by the total number of cases for all DRGs to determine the weighted average geometric mean charge for all DRGs.

   4. Divide the statewide geometric mean charge for each DRG by the weighted average geometric mean charge for all DRGs to derive the Iowa-specific weight for each DRG.

   5. Normalize the weights so that the average case has a weight of one.

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b. The hospital-specific case-mix index is computed by taking each hospital's trimmed claims from the hospital's 1998 specific cost reporting period; summing the assigned DRG weights associated with those claims; and dividing by the total number of Medicaid trimmed claims associated with that specific hospital for that period.

12. Calculation of Hospital-Specific DRG Payment

The final payment rate, as defined in Section 2, is used to determine the final payment made to a hospital. This final payment rate is multiplied by the weight associated with the patient's assigned DRG. The product of the final payment rate times the DRG weight results in the dollar payment made to a hospital.

13. Explanation of Additional or Reduced Payment to a Facility

Additional payment is made for approved cases meeting or exceeding the Medicaid criteria for day and cost outliers for each DRG. For claims with dates of services ending July 1, 1993, and after, 100% of outlier costs are paid to facilities at the time of remittance. Thresholds for the determination of these outliers are computed during the calculation of the Iowa-specific weights and rebasing. Reduced payments are incurred by a facility due to a patient's unusually short length of stay (short-stay outliers).

Long-stay outliers are incurred when a patient's stay exceeds the upper day-limit threshold. This threshold is defined as the greater of 23 days of care or two standard deviations above the average statewide length of stay for a given DRG. Reimbursement for long-stay outliers is calculated at 60% of the average daily rate for the given DRG for each approved day of stay beyond the upper day limit. Payment for long-stay outliers is made at 100% of the calculated amount and is made when the claim is originally filed for DRG payment.

Short-stay outliers are incurred when a patient's length of stay is greater than two standard deviations below the average statewide length of stay for a given DRG, rounded to the next highest whole number of days. Payment for short-stay outliers is 200% of the average daily rate for each day the patient qualifies up to the full DRG payment. Short-stay outlier claims are subject to PRO review and payment denied for inappropriate admissions.

Cases qualify as cost outliers when costs of service in a given case exceed the cost threshold. This cost threshold is determined to be the greater of two times the statewide average DRG payment for that case or the hospital's individual DRG payment for that case plus $16,000. Costs are calculated using hospital-specific cost to charge ratios determined in the base-year cost reports.

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Additional payment for cost outliers is 80% of the excess between the hospital's cost for the discharge and the cost threshold established to define cost outliers. Payment of cost outlier amounts shall be paid at 100% of the calculated amount and made when the claim is paid.

Hospitals that are notified of any outlier review initiated by the IFMC must submit all requested supporting data to the PRO within 60 days of the receipt of outlier review notification, or outlier payment will be forfeited and recouped.

In addition, any hospital may request a review for outlier payment by submitting documentation to the PRO within 365 days of receipt of the outlier payment. If requests are not filed within 365 days, the provider loses the right to appeal or contest that payment.

To verify that outlier costs are medically necessary and reasonable, the PRO selects a 10% random sample of outlier cases identified from fiscal agent claims data for all Iowa hospitals and bordering state hospitals. At least one case every six months per facility will be selected for review if available. This is a non-intensified review.

PRO staff review the cases to perform admission review, quality review, discharge review, and DRG validation. Questionable cases are referred to a physician reviewer for medical necessity and quality of care concerns. Day outlier cases are reviewed to identify any medically unnecessary days, which are "carved out" if determining the qualifying outlier days.

Cost outlier cases are reviewed for medical necessity of all services provided, to ensure that services were not duplicatively billed, to determine if services were actually provided, and to determine if all services were ordered by a physician. The hospital's itemized bill and remittance statement are reviewed in addition to the medical record.

On a quarterly basis, the PRO calculates denial rates for each facility based on completed reviews during the quarter. All outlier cases reviewed are included in the computation or error rates. Cases with denied charges that exceed $1,000 for inappropriate or non-medically necessary services or days are counted as errors.

Intensified review may be initiated for hospitals whose error rate reaches or exceeds the norm for similar cases in other hospitals. The error rate is determined based on the completed outlier reviews in a quarter per hospital and the number of those cases with denied charges exceeding $1,000. The number of cases sampled for hospitals under intensified review may change based on further professional judgment and the specific hospital's outlier denial history.